

**THE BANGLADESH FAMILY PLANNING
AND HEALTH SERVICES PROJECT
(388-0071)**

EVALUATION REPORT

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ABBREVIATIONS

| | |
|---------|---|
| AIDS | Acquired Immunodeficiency Syndrome |
| AVSC | Association for Voluntary Surgical Contraception (AVSC International) |
| BCG | Bacille Calmette-Guérin |
| BASICS | Basic Support for Institutionalizing Child Survival (project) |
| CA | Cooperating Agency |
| CBD | Community-based Distribution |
| CBS | Community Based Sales |
| CPR | Contraceptive Prevalence Rate |
| CPS | Contraceptive Prevalence Survey |
| CS | Child Survival |
| CYP | Couple Year of Protection |
| DFP | Directorate of Family Planning |
| DHS | Demographic and Health Survey |
| DPT | Diphtheria, Pertussis, and Tetanus |
| ELCO | Eligible Couple |
| EPI | Expanded Program of Immunization |
| EU | European Union |
| EWPI | East-West Population Institute |
| FHI | Family Health International |
| FP | Family Planning |
| FPAB | Family Planning Association of Bangladesh |
| FPHS | Family Planning and Health Services Project |
| FPLM | Family Planning Logistics Management (Project) |
| FPSTC | Family Planning Services Training Center |
| FWA | Family Welfare Assistant |
| FWV | Family Welfare Visitor |
| GOB | Government of Bangladesh |
| HA | Health Assistant |
| HIV | Human Immunodeficiency Virus |
| ICDDR,B | International Center for Diarrheal Disease Research, Bangladesh |
| IEC | Information, Education, and Communication |
| IEM | Information, Education, and Motivation Unit, Directorate of Family Planning |
| IMR | Infant Mortality Rate |
| IPC | Interpersonal Communications |
| IPPF | International Planned Parenthood Federation |
| IUD | Intrauterine Device |
| JHU/CCP | The Johns Hopkins University Center for Communication Programs |
| LGD | Local Government Division |
| LIP | Local Initiatives Program |
| LMIS | Logistics Management Information System |
| MCH | Maternal and Child Health |
| MIS | Management Information System |
| MLGRDC | Ministry of Local Government, Rural Development, and Cooperatives |
| MMR | Maternal Mortality Rate |
| MOHFW | Ministry of Health and Family Welfare |

| | |
|---------|---|
| NGO | Nongovernmental Organization |
| NIPORT | National Institute of Population Research and Training |
| NSC | National Steering Committee |
| OC | Oral Contraceptive |
| ODA | Overseas Development Administration (United Kingdom) |
| OR | Operations Research |
| ORS | Oral Rehydration Salts |
| PDEU | Population Development and Evaluation Unit |
| PHC | Primary Health Care |
| PHN | Population, Health, and Nutrition |
| PIL | Project Implementation Letter |
| PIO/T | Project Implementation Order/Technical Service |
| PP | Project Proformas |
| PSI | Population Services International |
| QA | Quality Assurance |
| QES | Quality, Expansion, and Sustainability |
| RAPID | Resources for the Awareness of Population Impact on Development |
| REM | Research, Evaluation, and Monitoring |
| RFP | Request for Proposal |
| RH | Reproductive Health |
| RMP | Regional Medical Practitioner |
| SMC | Social Marketing Company |
| SMP | Social Marketing Project |
| TA | Technical Assistance |
| TAF | The Asia Foundation |
| TAI | Technical Assistance, Inc. |
| TAPP | Technical Assistance Project Proforma |
| TFR | Total Fertility Rate |
| TT | Tetanus Toxoid |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Emergency Fund |
| URC/B | University Research Corporation/Bangladesh |
| U.S. | United States |
| USAID | United States Agency for International Development |
| USAID/B | United States Agency for International Development/Bangladesh |
| USAID/W | United States Agency for International Development/Washington |

EXECUTIVE SUMMARY

The USAID/Bangladesh (USAID/B) Family Planning and Health Services Project (August 31, 1987 through August 30, 1997) provides US\$300 million in population and health assistance. It is one of the world's largest USAID population and health programs. Overall, its multi-dimensional support to the Bangladesh National Program has contributed significantly to the success of the program, especially through strengthening the private sector.

The purposes of this evaluation were to assess progress of the project to date and make recommendations for refinement during the final two years. By and large, the project has achieved or exceeded its goals and objectives. In collaboration with the Government of Bangladesh (GOB) as well as other donors and local organizations, it has been a major factor in the tremendous expansion of population and health services in Bangladesh. Further, it demonstrates clearly that USAID's intellectual and technical leadership in the population and health services arena can do much to stimulate National Program growth. While the team recommends no substantial changes in direction, the remaining period of the project offers an opportunity to take advantage of significant changes underway in the socioeconomic environment, strengthen the focus on service quality, increase attention to stimulating the use of long-term methods, and gradually move toward a more manageable structure for the follow-on project.

Evaluation Methodology

Following an initial briefing in Washington, the evaluation took place in Bangladesh from March 19 through April 13, 1995. Two team members spent several additional days in Dhaka. The methodology included interviews, review of documents, and site visits. The team was briefed by USAID/B and presented its findings at a series of briefings to USAID/B, the Ministry of Health and Family Welfare (MOHFW), and project partners, including other donors, Cooperating Agencies (CAs), and other local institutions.

Project Goals and Objectives

The following is a summary of the project's progress in achieving its goals and objectives, based on findings from several national surveys conducted between 1986 and 1994:

- **Decrease in the total fertility rate (TFR) from 4.6 in 1991 to 3.8 in 1997.** The TFR declined from 5.8 in 1986 to 3.4 in 1993/94. This is a drop of over 40 percent in less than eight years and about two-thirds of what is needed to achieve replacement fertility.
- **Decline in the infant mortality rate (IMR) from 118 in 1991 to 107 in 1997.** The IMR declined about 25 percent between the early 1980s and the early 1990s, from about 117 to about 87 deaths per 1,000 births.

- **Increase in the contraceptive prevalence rate (CPR) from 40 percent in 1991 to 50 percent in 1997.** The overall CPR increased from 25.3 percent in 1986 to 44.6 percent in 1993/94. During the same period, the CPR for modern methods essentially doubled, from 18.4 percent to 36.2 percent.
- **Increase in contraceptive users from 9.9 million in 1991 to 14.5 million in 1997.** The Logical Framework apparently contained an error. Based on the 1991 census and the 1991 Contraceptive Prevalence Survey (CPS) (which gave a 1991 CPR of 40), there were 7.8 million users in 1991, not 9.9 million. Estimating a CPR of 50 in 1997, there will be 12.1 million users in 1997. In 1994, the estimated number of users was 10.1 million.
- **Increase in urban immunization of women and children from 25 percent in 1988 to 85 percent in 1997.** The 1994 National Coverage Evaluation Survey showed that in 1994, 82 percent of urban mothers had received two doses of Tetanus Toxoid (TT), compared to 80 percent nationwide. Urban immunization rates for children ages 12-23 months were as follows: 93 percent for Bacille Calmette-Guérin (BCG) (compared to 96 percent nationwide); 83 percent for Diphtheria, Pertussis, and Tetanus (DPT3) (compared to 88 percent nationwide); 76 percent for measles (compared to 86 percent nationwide); and 75 percent for fully immunized (compared to 84 percent nationwide).

Two other statistics also support the conclusion that this project has had a significant impact on maternal and child health:

- The under-five mortality rate, representing the number of children per thousand born who die before age 5, declined from about 180 in the early 1980s to about 133 in the early 1990s, a decline of about 26 percent.
- The maternal mortality rate (MMR) is about 5.5 maternal deaths for every 1,000 births. This means that at the current level of fertility, during the full reproductive life span about two percent of women will die of maternity-related causes. Measurement of MMR is difficult and costly, and it is unknown whether, and how much, this rate has declined in recent years. However, even if it had remained unchanged for the past 20 years, the total number of women dying from maternity-related causes would have been much lower due to the fertility decline. The number of married women of reproductive age has increased by more than 50 percent. If the TFR were still over seven, about 200,000 women who are alive today would have died from a maternity-related cause.

Project Organization

This is a very complex project with diverse elements implemented through numerous local and international organizations. It also involves a large number of development partners funded through various USAID/Washington (USAID/W) and USAID/B agreements. These partners provide specialized assistance to the program. Each agreement requires separate funding actions as well as administrative and technical oversight by USAID in Dhaka and, in some

cases, in Washington, making project management very labor intensive. The follow-on project would be well served by a far simpler structure. In addition, it should allow for more flexibility in allocating resources among project elements and a streamlined decision-making process.

Project Structure

The Project is organized under four components, some of which contain multiple subprojects:

- Component I focuses on the public sector and aims to improve and decentralize family planning service delivery. It also supports the National Expanded Program of Immunization (EPI) Program as part of the GOB's child survival efforts.
- Component II supports the Social Marketing Company (SMC) in promoting and distributing contraceptives and oral rehydration salts (ORS).
- Component III focuses on supporting nongovernmental organizations (NGOs) in providing family planning and maternal and child health (MCH) services through cooperative agreements with three international and two national organizations.
- Component IV provides program support services, including commodities, research, evaluation, technical assistance, monitoring, and information, education, and communication (IEC).

Component I: Assistance to the Public Sector

This component has three elements: (1) the Local Initiatives Program (LIP), (2) logistics management, and (3) municipal immunization. Another element, improving satellite clinics, was never implemented.

Local Initiatives Program

USAID's investment in the innovative LIP is very sound. Designed to improve the capacity of local officials to manage family planning services, it has achieved this objective and fostered community ownership of and responsibility for FP/MCH services. LIP now covers about 15 percent of the country, with 103 *thana* teams (the end-of-project target) reaching a population of 10.23 million with 1.78 million eligible couples in 501 unions. There are 25,000 volunteers (almost all women) who provide doorstep health/family planning information and contraceptives as well as encourage women to attend satellite clinics for clinical methods and EPI. Other field personnel associated with LIP are government staff.

The 1993 CPR for modern methods in LIP areas was 58 percent, compared to the national average of 36 percent, and rose to 62 percent in 1994. LIP areas also had a higher prevalence for clinical methods in 1994 (23 percent compared to the national average of 17 percent). Visits by government workers are more frequent in LIP areas than in other areas,

with 87 percent of clients visited within the last six months compared to the national average of 38 percent.

Key issues for the remaining project period include decentralization of program administration, phasing down in high prevalence areas while focusing visits on hard-to-reach and underserved populations, and determining an appropriate rate of expansion.

Logistics Management

Improvements in supply management have contributed to the impressive increase in contraceptive prevalence. The vehicle for USAID support is a buy-in for technical assistance and training from the Office of Population's worldwide Family Planning Logistics Management (FPLM) Project. The project has trained more than 11,000 family planning workers, supervisors, and storekeepers in the principles of logistics management. It has designed and implemented with the Directorate of Family Planning (DFP) an automated logistics information system with 90 percent of the 467 *thanas* reporting logistics data monthly. Rates of contraceptive stock-outs at the *thana* level have declined dramatically from 23 percent in 1989 to under five percent by 1994. During the same period, there was a significant rise in the quantity and types of contraceptives distributed.

Institutionalization of logistics management within DFP has been slow, with system maintenance still heavily dependent on the large FPLM/Dhaka staff. Efficiency is another issue. While the system has minimized stock-outs, it needs to become more efficient if it is to handle the anticipated increased volume of contraceptives in the future and if it is to become sustainable by the GOB. Also, a 1994 survey of contraceptive stocks in the NGO program revealed that stock-outs were common, especially for injectables (over 30 percent) and intrauterine devices (IUDs) (25 percent). The latter is particularly noteworthy, given the fact that the GOB's principal goal is to increase clinical use.

For the next two years priority attention is needed in transferring the logistics information system to MOHFW and providing logistics assistance and training to the NGOs.

Municipal Immunization

Between 1988 and 1992, the level of immunization for both urban infants and urban mothers increased from under 25 percent to over 80 percent. Under USAID/B's guidance, this project has been instrumental in bringing together the MOHFW and the Ministry of Local Government, Rural Development, and Cooperatives (MLGRDC) to form the Interministerial Urban Primary Health Care (PHC) Coordinating Committee, with far-reaching consequences both for urban health systems and for effectively integrating health and family planning activities at the local level.

The urban EPI program covers the four major cities (Dhaka, Rajshahi, Khulna, and Chittagong) and 84 out of 133 municipalities with a combined population of 22 million, or 20 percent of the national population. Urban areas have little health infrastructure. The urban EPI program has successfully pulled together multiple disparate resources to set up fixed and outreach EPI

centers. These have included GOB hospitals, municipal and private clinics, and NGO hospitals, clinics, and dispensaries. Critical to the program's success has been the close collaboration between the MOHFW's National EPI Program, the International Center for Diarrheal Disease Research, Bangladesh's (ICDDR,B's) Urban FP/MCH Extension Project, the MLGRDC, municipal governments, UNICEF, and various NGOs. Under a cost sharing partnership between UNICEF and the USAID-funded BASICS Project, there are nine Bangladeshi urban operations officers located in four divisions. These staff persons are beginning to involve city and municipal administrations successfully in coordinating and managing the EPI program.

There is an urgent need for urban health systems, given the projected doubling of the urban population in the next 10 years, with one-third or more being poor slum dwellers.¹ Priorities for the final two years include strengthening the disease surveillance system, further developing program monitoring tools, strengthening the capacities of Ministry and local authorities to manage services, and supporting the Urban PHC Coordinating Committee.

Component II: Social Marketing Company

SMC is the world's largest social marketing company. In 1994, it accounted for nearly 1.9 million couple years of protection (CYPs). USAID began its social marketing support for family planning in Bangladesh in 1974. ORS was added in 1983. In 1990, the social marketing project became the Social Marketing Company, a non-profit private limited Bangladeshi company. Until 1993, USAID supplied all SMC's condoms and continues to provide a single oral contraceptive (OC). Aside from a small stock of USAID-supplied ORS, SMC has always purchased ORS on the local market. SMC has attracted two new donors of contraceptives, with the European Union (EU) now providing condoms and the Overseas Development Administration (ODA) providing one OC. In addition, at the time of the evaluation, the United Nations Population Fund (UNFPA) was planning to contribute a condom manufacturing plant and a pill tableting operation.

SMC demonstrated impressive progress between 1984 and 1994: annual condom sales rose from 115 million to almost 151 million; OC sales rose from 2.1 million to 11.6 million; revenue increased from 17.6 million taka to 164.4 million taka; the number of stockists rose from 3,500 to 8,000 and the number of retail outlets from 20,000 to 84,500; and operating cost recovery rose from 21 percent to 92 percent. Operating cost excludes contraceptive commodity costs.

SMC has already achieved or exceeded its end-of-project goals with respect to CYPs, condom sales, and ORS sales. Its OC sales, currently at 12 million (with a 1997 target of 17.5 million) have been adversely affected by changes in USAID/W's OC suppliers (causing brand changes) and USAID/W's decision to reduce its commodity support from three brands to one. Total cost recovery, targeted at 42 percent in 1997, is now 35 percent. SMC has recently received permission from the GOB to market injectables and is evaluating the feasibility and appropriateness of doing so. SMC is on track with respect to training regional medical practitioners (25,000 trained to date) but far behind in its training of pharmacists and school children.

¹ This is an issue that is addressed more fully in the companion Strategic Options Report.

SMC has had continuous resident CA support and CA-channeled funding for over 20 years. Serious efforts toward organizational and administrative sustainability did not begin until the formation of the private company in 1991. The final two years of the project offer an opportunity for transition to a direct USAID-SMC assistance instrument, if SMC meets the technical qualifications, and to reformulate the nature and type of external assistance USAID should provide to SMC.

Component III: Nongovernmental Organizations

USAID/B has made a sound investment in supporting NGOs. They have been key innovators in pushing the program forward and influencing national policy. They have also served as catalysts to improve the quality of care at government sites and have convinced the government of the efficiency of targeting newlyweds and low parity couples.

The NGO component has established a private sector delivery system through its network of 115 NGOs providing FP/MCH services at 322 delivery sites in all six divisions. The NGOs provide approximately 17 percent of the country's overall FP services. It is estimated that in 1994 the NGOs served 1.7 million users.

This component is implemented through four cooperative agreements (three with U.S. groups and one with the national International Planned Parenthood Federation [IPPF] affiliate) plus a separate agreement with Family Planning Services and Training Center (FPSTC). All the CAs have modern method CPRs that are significantly higher than the national level of 36 percent. Although clinical methods are a higher proportion of all modern methods nationwide than they are in NGO programs, clinical methods at NGO programs increased slightly between 1993 and 1994. At the national level, these methods declined slightly between 1991 and 1994.

The NGO component has been instrumental in expanding coverage in three ways: (1) access to services for underserved groups; (2) expansion at existing service sites; and (3) geographic expansion to new areas. In terms of quality, all CAs and many NGOs have increased the number of qualified doctors on staff to monitor quality, and there are many well-trained family welfare visitors (FWVs) in the system. Most NGOs have met training targets. Also, there is limited use of indicators to monitor quality and existing clinical standards although manuals have yet to be adopted and implemented widely. Both financial and institutional sustainability have been relatively slow.

During the remaining project period, priority areas for attention are developing strategic plans for sustainable high-quality, cost-effective services by CAs/NGOs, improving the quality monitoring system, and accelerating the phase down of broad-scale doorstep delivery through use of depots, satellite clinics, and—in high prevalence areas—selective visitation patterns targeting underserved high-risk groups.

Component IV: Support Services

This component has three elements: (1) contraceptives, (2) research, evaluation, and monitoring (REM), and (3) information, education, and communication.

Contraceptives

Since 1987, USAID has provided US\$71.1 million worth of contraceptives, the vast majority were provided prior to 1992. USAID/B is also supporting the construction of 210 *thana* storerooms for the DFP, with 18 now operational and another 92 under construction. Despite a series of delays, the remaining 100 are expected to be complete by the end of the project. However, as physical infrastructure development is not an area in which the agency excels, future support of this type is not recommended.

While it is reasonable to expect that donors will continue to provide contraceptives in the near term, it is essential that the GOB develop a realistic plan for meeting its contraceptive requirements after 1997, when many of the current donor projects end.

Research, Evaluation, and Monitoring

USAID/B has made a substantial investment in the use of applied research to help guide program implementation. REM services, provided through a variety of CAs and local institutions, have resulted in a number of significant studies that have contributed to the success of the National Program. These include the Contraceptive Prevalence Survey/Demographic and Health Survey to document the demographic impact of the National Program; research in collaboration with local institutions to bring affordable service delivery innovations into government programs and to test organizational and service delivery structures in urban areas; and a cost-benefit analysis of the National Family Planning Program showing that program expenditures are an excellent financial investment for the government. In addition, this component has engaged in awareness-raising and advocacy activities.

REM services have involved a range of technical assistance and training/capacity-building activities for government and private organizations, but the need remains for increased technical capacity-building in both sectors. This assistance should emphasize the development of GOB institutions as "consumers" of REM services and private institutions as the "suppliers" of those services. Also, the imperative remains to take the best advantage of USAID-supported REM activities as well as the FP Future Challenges Committees, working groups, and policy/decision-making authorities. Of particular importance in the near term is supporting operations research (OR) related to management improvement, quality of care, and sustainability.

Information, Education, and Communication

Initially, this activity was focused on providing technical assistance to the MOHFW Information, Education, and Motivation Unit (IEM) Unit, its contractors, NGOs, and other agencies. Because of the lack of a comprehensive national IEM strategy and slow implementation of activities programmed for the IEM Unit, the project was reformulated in 1992 to increase the CA support role with emphasis on extending a promising rural communication program (Jiggasha), expanding training and production of IEC materials, sponsoring national workshops for policy-makers, and communications and media research.

The activity has resulted in some impressive achievements. Since 1993, Jiggasha has extended to eight *thanas*, with 3,051 Jiggasha centers serving about 295,000 eligible couples. The Generic Curriculum for Interpersonal Communication and Counseling Training, the Fieldworkers Guide, and the Method Specific Booklet represent examples of inter-organizational collaboration in producing training and IEC materials. Workshops have provided 72 Bangladeshis with advanced training in communication, while other groups have participated in workshops on message development and media relations. The CA has produced radio and TV spots, folk songs, a short feature film, and a 25-episode radio drama in support of FP/MCH. The production of the *National FP/MCH IEC Strategy: 1993-2000* is a significant achievement involving 41 key players from government, NGOs, the private sector, and donors, but it addresses predominantly FP issues and has little MCH content.

Two key issues merit attention during the remaining project period. The first is IEC coordination. Efforts to date have been unsuccessful in integrating MCH and FP in a comprehensive IEC strategy. The second is greater capacity development in the IEM Unit. This capacity is now limited to development and production of basic in-house print and audiovisual IEC materials.

Key Recommendations

1. USAID should proceed with the design of a follow-on assistance package to continue support to the National FP/MCH Program in Bangladesh.
2. USAID and the GOB should ensure that the follow-on FP/MCH assistance package permits flexibility in allocating resources among project elements; contains a streamlined approval and concurrence process for implementing activities; and allows the direct USAID support of NGO and private sector initiatives. Specifically, the team recommends that:
 - USAID/B and the GOB develop mechanisms to allow more flexibility in allocating resources among project activities in the follow-on project.
 - USAID/B and the GOB agree to streamline the required approval and documentation process in the follow-on project, including consolidating the cumbersome and time-consuming process of implementing agreed upon activities through numerous individual Technical Assistance Project Proformas (TAPPs), PP/PCPs, and Project Implementation Letters (PILs).
 - The GOB establish clear and workable procedures to allow the government to pay or waive CD/VAT taxes on project-purchased goods and commodities.
3. USAID/B and LIP should develop a strategy during the final two-year period that articulates a plan to phase down in high prevalence/quality areas, including the criteria to examine when considering phase-down, the role of the volunteers, bridging support required, and service delivery mechanisms to maintain the past achievements, assure high use by newlyweds and low parity couples and access to clinical methods.

4. Priorities that USAID/B's urban immunization project should address in the next two years include the following:
 - Strengthen the disease surveillance system and further develop program monitoring tools (such as the lot quality assessment methodology) in order to improve the quality and coverage in urban areas.
 - Strengthen the capacities of MLGRDC, city corporations, and municipalities to plan, coordinate, implement, and manage the EPI, FP, and related essential MCH services in order to help develop functioning urban health systems.
 - By actively following up and supporting the activities of the Interministerial Urban PHC Coordinating Committee, assure that needed new directives on implementing urban health systems are formulated and disseminated to strengthen and bring the necessary support for the development of city and municipal health authorities.
 - USAID/B should assist BASICS to make the transition vis-à-vis the GOB from providing technical assistance (TA) in only urban EPI management to an expanded role of assistance to other high impact child survival (CS), reproductive health (RH), and FP programs. EPI should serve as the entry point for reaching mothers with other essential services.
5. USAID/B, SMC, and Population Services International (PSI) should begin now to establish a transition strategy for the remainder of the present project period and the early phase of the follow-on project.
6. USAID/B should work with the national NGOs and CAs to develop a joint five-year strategic plan that would focus on CAs' designing delivery service systems able to provide quality services and information in a cost-effective, client-sensitive manner.
7. NGO efforts need to be intensified in the next two years and beyond to ensure that quality of services is further improved, services are expanded both vertically and horizontally, and sustainability is addressed in the near future.
8. USAID/B should work with MOHFW and other donors to ensure that a fully functioning supervision system is in place to ensure quality service delivery. This supervision system may include a cadre of quality surveillance teams to monitor and correct deficiencies as soon as possible.
9. USAID/B should encourage the GOB to chair a donors meeting in 1995 and develop a plan that identifies funding sources and gaps to meet the program's contraceptive requirements after 1996-97.
10. USAID/B should continue to give high priority to supporting OR related to management improvement, quality of care, and sustainability. USAID/B should also give priority to designing and testing alternative service delivery systems to address FP financial issues.

11. The proposed family planning provider promotion strategy with logos must be carefully coordinated with a clinical quality assurance program to avoid the perception of "endorsing" substandard providers and undermining efforts at promoting a message built around (certified) quality FP providers.
12. The implementation plan of the national FP/MCH IEC strategy should be reformulated to support a more comprehensive and integrated FP/MCH effort, especially where there are now obvious opportunities and programmatic links (e.g., EPI and postpartum family planning, breastfeeding and child spacing, permanent methods and maternal health, etc.).

1 INTRODUCTION

The USAID/Bangladesh (USAID/B) Family Planning and Health Services Project (FPHS) (August 31, 1987 through August 30, 1997) provides US\$300 million in population and health assistance. The project goal is to increase sustainable economic participation by reducing current high levels of fertility and infant, child, and maternal mortality and morbidity. The purpose is to improve access to and use of high-quality, efficient, sustainable family planning and maternal and child health services.

Project assistance is organized under four components, some of which contain multiple sub-projects:

- Component I focuses on the public sector, and aims to improve and decentralize family planning (FP) service delivery. It also supports the National Expanded Program of Immunization (EPI) as part of the government of Bangladesh's (GOB's) child survival efforts.
- Component II supports the Social Marketing Company (SMC) in promoting and distributing contraceptives and oral rehydration salts (ORS).
- Component III focuses on supporting nongovernmental organizations (NGOs) in providing family planning (FP) and maternal and child health (MCH) services through agreements with three international and two national organizations.
- Component IV provides program support services, including commodities, research, technical assistance, evaluation, monitoring, and information, education, and communication (IEC).

The purpose of this evaluation is to assess the progress and impact of the FPHS Project. The project uses the following indicators as measures of achieving project goals and objectives:

- Decrease in the total fertility rate (TFR) from 4.6 in 1991 to 3.8 in 1997.
- Decline in the infant mortality rate (IMR) from 118 in 1991 to 107 in 1997.
- Increase in the contraceptive prevalence rate (CPR) from 40 percent in 1991 to 50 percent in 1997.
- Increase in contraceptive users from 9.9 million in 1991 to 14.5 million in 1997.²
- Increase in urban immunization of women and children from 25 percent in 1988 to 85 percent in 1997.

² Based on the 1991 census and the 1991 CPS (which gave a 1991 CPR of 40), there were an estimated 7.8 million contraceptive users in 1991, not 9.9 million. Estimating a CPR of 50 in 1997, there will be 12.1 million users in 1997. In 1994, the estimated number of users was 10.1 million.

Findings from several national surveys conducted between 1986 and 1994 show the following:

- The fertility rate declined from 5.8 in 1986 to 3.4 in 1993/94—a drop of over 40 percent in less than eight years and about two-thirds of what is needed to achieve replacement fertility.
- The infant mortality rate declined about 25 percent between the early 1980s and the early 1990s, from about 117 to about 87 deaths per 1000 births.
- The overall CPR increased from 25.3 percent in 1986 to 44.6 percent in 1993/94. During the same period, the CPR for modern methods nearly doubled, from 18.4 percent to 36.2 percent.
- According to the 1994 National EPI Coverage Evaluation Survey, nationwide in 1994, 80 percent of mothers of childbearing age had received two doses of tetanus toxoid (TT). Nationwide immunization coverage rates for children ages 12-23 months in 1994 were as follows: 96 percent for BCG, 88 percent for diphtheria, pertussis, and tetanus (DPT)3, 86 percent for measles, and 84 percent for fully immunized. The 1993/94 Demographic and Health Survey (DHS) gave a full immunization rate of 60 percent for children ages 12-23 months compared to a rate of less than 20 percent in a 1989 survey.
- The under-five mortality rate—the number of children who die before age 5 out of every 1000 born—declined from about 180 in the early 1980s to about 133 in the early 1990s, a decline of about 26 percent.
- The maternal mortality rate (MMR) is about 5.5 maternal deaths for every 1000 births (meaning that at the current level of fertility, during the full reproductive lifespan about two percent of women will die of maternity-related causes). Measurement of changes in MMR is difficult and costly, and it is unknown whether, or how much, this rate has declined in recent years. However, even if the MMR had remained unchanged for the past 20 years, the total number of women dying from maternity-related causes would have been greatly reduced due to fertility decline. With an MMR of 5.5, in the mid-1970s nearly 30,000 women died annually from maternity-related causes. Fertility decline has brought the annual number of maternity-related deaths down to about 20,000 even though the number of married women of reproductive age has increased more than 50 percent in 20 years. If the TFR was still over seven, the annual number of maternity-related deaths would now be over 40,000. About 200,000 women who are alive today would have died from a maternity-related causes during the past 20 years had fertility not declined.

2 OVERVIEW OF FINDINGS AND CONCLUSIONS

2.1 Project Overview

The FPHS Project is one of USAID's largest population/health assistance programs. The FPHS Project plays a critical role in facilitating and implementing the National FP/MCH Program in all sectors—public, private, and NGO. The project has contributed significantly to the remarkable success of the National Program during the last eight years—especially in the private sector. While there have been some environmental and diplomatic challenges along the way, USAID/B has exercised leadership and creativity in several areas. It has, for example, greatly expanded the use of NGOs to involve local personnel, supported the development of an excellent social marketing system, and designed a policy and strategy for promoting quality, expansion, and sustainability across the board. These initiatives, among others, have contributed substantially to the infrastructures for upgrading service delivery programs and are reflected in the country's impressive CPR and TFR and the EPI program.

The management and administration of this large project, which contains many diverse elements, is very labor intensive and complex for all parties involved—USAID, the GOB, Cooperating Agencies (CAs), NGOs, etc. USAID/B implements the FPHS Project through numerous local and international organizations. In addition, there are a large number of development partners, including international organizations, funded through various USAID/Washington (USAID/W) and USAID/B agreements that provide specialized assistance to the family planning/maternal and child health (FP/MCH) program. Each agreement requires separate funding actions as well as administrative and technical oversight on the part of USAID staff (both in Dhaka and, in some cases, Washington). All parties associated with the FPHS Project spend considerable time and effort moving paper from one place to another, time that could be spent more productively on implementation activities. For example, each component of the bilateral project requires separate documentation and action on the part of USAID/B (through project implementation orders for technical service [PIO/Ts] and project implementation letters [PILs]) and the GOB (e.g., separate Technical Assistance Project Proformas [TAPPs] or project proformas [PP/PCPs] are now required for each component of the FPHS Project).

2.2 Overall Findings

Although USAID/B is not the only donor that supports the government, its investment has significantly contributed to the increase in contraceptive users. Of the estimated 10.1 million users in 1994, about 3.8 million received FP services from GOB facilities and another 2.9 million from government family welfare assistants (FWAs). Within the areas supported by USAID/B as well as the country as a whole, significant gains have been made in ensuring adequate supplies of contraceptives in the field; improving coverage of immunization in urban areas; and decentralizing responsibility and implementation of family planning to the community level. Although AVSC International and Pathfinder International have assisted the Ministry of Health and Family Welfare (MOHFW) in the development of quality assurance (QA) criteria, these criteria have not been implemented widely, making it impossible to assess client satisfaction at this level. The subproject that was specifically targeted to increase the capacity of satellite clinics was never implemented; therefore, this project element cannot be evaluated.

Even though USAID was not able to directly support satellite clinics under the public sector, USAID/B has provided significant support via the NGOs and the Local Initiatives Program (LIP) with considerable success.

USAID/B focused its policy advocacy and planning efforts in its operations research (OR) work with the International Center for Diarrheal Disease Research, Bangladesh's (ICDDR,B's) rural/urban extension project; in policy dialogue through the "Future Challenges of FP/MCH" National Steering Committee; in developing and applying population and FP computer models; and in capacity building through technology transfer. USAID/B provided assistance to the government to develop its fourth five-year plan (1991-95) as well as publish three annual Bangladesh demographic data sheets and four policy papers.

2.3 Conclusions

As the associated program review³ indicates, USAID should stay actively engaged in the population and health sector in Bangladesh. USAID/B should build on its principal areas of assistance to date and incorporate its special expertise and comparative advantage into the design and implementation of follow-on assistance. However, future USAID assistance to the National FP/MCH Program should be structured differently. In its current form, the FPHS Project is cumbersome, time consuming, and inefficient. While little can be done to alter the FPHS structure in the next two years, there are several lessons that should be incorporated into the next USAID FP/MCH project. These include flexibility in allocating resources among project activities; streamlining the approval process especially with respect to the GOB; continued direct USAID/B support to the private and NGO sectors; and creating a more holistic and seamless package of USAID/B assistance activities from both bilateral and central (i.e., USAID/W) sources.

Naturally, any future USAID assistance in this sector should take into account current and expected assistance activities of other donors, especially UNFPA, the World Bank and its consortium, the Asian Development Bank, and the Japanese. With respect to the Japanese, USAID should continue to be proactive in engaging the Japanese in the population, health, and nutrition (PHN) sector through the Common Agenda. Specific areas of common interest include family planning, immunization, support of ICDDR,B, and HIV/AIDS. In the latter instance there are possibilities for collaboration in targeting FP/MCH services in underserved areas through the GOB and/or a national NGO.

2.4 Recommendations

1. USAID/B should proceed with the design of a follow-on assistance package to continue support to the National FP/MCH Program in Bangladesh.
2. USAID/B and the GOB should continue the existing project grant agreement/funding format that divides USAID assistance into bilateral and unilateral portions that (following the project grant agreement signing) provides for USAID/B to continue to manage the unilateral portion of the grant directly with its private sector partners (e.g., NGOs, SMC).

³ The Strategic Options Report

3. USAID/B and the GOB should ensure that the follow-on FP/MCH assistance package permits flexibility in allocating resources among project elements; contains a streamlined approval and concurrence process for implementing activities; and allows the direct USAID/B support of NGO and private sector initiatives. Specifically, the evaluation team recommends the following:
 - USAID/B and the GOB should develop mechanisms to allow more flexibility in allocating resources among project activities in the follow-on project.
 - USAID/B and the GOB should agree to streamline the required approval and documentation process in the follow-on project or projects, including consolidating the cumbersome and time-consuming process of implementing agreed upon activities through numerous individual TAPPs, PP/PCPs, and PILs.
 - The GOB should establish clear and workable procedures to allow the government to pay or waive CD/VAT taxes on project purchased goods and commodities.

3 COMPONENT I: THE PUBLIC SECTOR

3.1 Background

About 38 percent of the family planning services in Bangladesh are delivered through GOB facilities, and an additional 42 percent are provided by fieldworkers, of whom around 70 percent are GOB FWAs. The FPHS Project plays an important role in supporting public sector family planning and MCH services by promoting decentralization of the service delivery system, increasing planning and management capacity, improving logistics management, supporting satellite clinics, and expanding urban EPI. According to the project document, assistance in this component is expected to result in (1) an increase in users from 6.8 million to 9.8 million; (2) GOB clients reporting satisfactory services based on established quality of care indicators; and (3) 5,300 satellite clinics meeting national standards by 1995.

3.2 Local Initiatives Program

LIP was designed to improve the capacity of local officials to manage family planning services. It consists mainly of small family planning grants to communities for training of local leaders. In the past two years, project volunteers have also served as effective promoters of EPI and other health services especially during satellite clinics. LIP, which currently covers approximately 15 percent of the country, already has 103 *thana* teams in place reaching a population of 10.23 million with 1.78 million eligible couples (ELCOs) in 501 unions.

3.2.1 Findings

General. The CPR in 1993 for modern methods in LIP areas was much higher (58 percent) than the national average (36 percent). By 1994, the LIP CPR had risen four percentage points to 62 percent. LIP catchment areas also had a higher prevalence for clinical methods in 1994 than the national average: 23 percent as compared to the national average of 17 percent for clinical methods.

Quality. Recognizing the need to improve quality of clinical services, LIP has encouraged the establishment of *thana* teams composed of administrative staff and clinical/non-clinical service providers from the government. LIP has also supported the training of government FWAs and family welfare visitors (FWVs) on injectables in 14 *thanas*.

LIP areas use volunteers, almost all of whom are women (a total of 25,000), who provide health/family planning door-step information and contraceptives as well as encouraging women to attend satellite clinics for clinical methods and EPI. Attendance rates at the satellite clinics in LIP areas are usually much higher than those in non-LIP areas, thereby promoting opportunities for women in LIP areas to have contact with more skilled medical personnel.

Based on rapid assessment surveys, in LIP areas, 87 percent of clients had been visited within the last six months by a volunteer, compared to the national average of 38 percent for clients visited by an FWA in the same time period. This is because each volunteer, under the supervision of an FWA, covers fewer clients and can visit clients more frequently.

Expansion. LIP is a very energetic program capable of further expansion, vertically and horizontally, if management functions in LIP headquarters such as regional training and technical assistance can be decentralized.

Between 1992 and 1994, the number of LIP unions increased from 166 to 501. However, LIP has only begun to concentrate on underserved groups in a focused way during the past year.

Sustainability. LIP's most important contribution to sustainability has been its effective training orientation that has enabled communities to assume greater responsibility for implementing family planning services and community leaders to direct fiscal support to the program.

LIP assists in developing local-level action plans, involving illiterate women in community decision making and strengthening management capacities. This is accomplished through the use of small seed grants from LIP coupled with a 10 percent minimum matching cash contribution from the local community. To date, 88 *thanas* have participated or are participating in this innovative program.

(US\$1.25) Other than the 25,000 volunteers who receive an average of 50 taka (US\$1.25) each as a monthly transport allowance (although some *thanas* pay nothing to the volunteers), all field personnel associated with LIP belong to and are funded through the governmental system.

Although many of the *thana* teams have functioned for several years, there has not been any phase-down of LIP funding and technical assistance (TA) support of unions or *thanas*. All operations to provide technical assistance are implemented from LIP/Dhaka, at present a highly centralized organization.

A key part of LIP's success has been the development of real commitment by *thana*-level political and administrative personnel to improve their local situations. Through this process these individuals have a better understanding of existing problems and contribute to and participate in addressing the constraints within their communities.

LIP has had limited success in its attempts to train volunteers in revenue generation or obtaining small business loans.

3.2.2 Conclusions

USAID's investment in the innovative LIP program is very sound. It has been key in improving managerial capability and fostering community ownership and responsibility for FP/MCH services. The commitment that LIP has helped to create at the local level has allowed services to continue, regardless of transfers in government officers at the *thana* level.

By improving management systems, particularly supervision and local planning including budgeting, and providing communities with real choices, LIP has been very successful in increasing the prevalence of modern methods, including clinical.

Although LIP is focused on developing local capacity, it is also in a unique position to identify areas nationally that need to be strengthened. However, LIP should not try to provide all types of technical assistance but should serve as a clearinghouse to assure that needs are addressed at the local level.

3.2.3 Recommendations

4. USAID/B and LIP should develop a strategy during the final two-year period that articulates a plan to phase down activities in high prevalence/quality areas. The criteria for phasing down should address the future role of volunteers; support needed during the transition period; and service delivery mechanisms needed to maintain past achievements, assure high use by newlyweds and low parity couples, and assure access to clinical methods.
5. After the completion of an independent study of full programmatic costs and impact, USAID/B should seriously examine the rate of LIP expansion. USAID/B should assess Technical Assistance, Incorporated's (TAI's) capability for self-decentralization at Dhaka headquarters.
6. Together with the donors, the ICDDR,B, and the CA/NGO community, LIP should use its contacts with the GOB to encourage charging for services. In addition, LIP should consider conducting an OR study on cost recovery in one of its areas.
7. LIP should develop a sustainability plan for its volunteers (focusing on developing means of revenue generation) and pursue various mechanisms for channeling small credit to them.

3.3 Logistics Management

One FPHS Project output is an expanded and improved contraceptive logistics system in the Bangladesh family planning program. To achieve this output, USAID/B has (1) provided contraceptives to the National Program (which is discussed later in this report); and (2) provided technical support in logistics management.

The USAID/W vehicle for improving the contraceptive logistics system in the country is through technical assistance and training from the Office of Population's worldwide Family Planning Logistics Management (FPLM) project. The FPLM/Dhaka operation supports three resident expatriate advisors and approximately 30 local technical and support staff. FPLM/Dhaka is providing technical assistance and training to the Directorate of Family Planning (DFP) and, more recently, to USAID-supported national family planning NGOs.

Technical assistance is provided in all components of logistics including logistics information systems, forecasting, procurement, warehousing, and distribution. FPLM/Dhaka uses a local subcontractor to provide logistics training to family planning fieldworkers, supervisors, and storekeepers. FPLM/Dhaka developed and implements an automated contraceptive logistics information system for the National Family Planning Program. Through a local subcontract, FPLM/Dhaka conducts annual surveys of contraceptive stock in the government's program.

The FPLM/Dhaka staff prepares annual estimates of contraceptive requirements for the national family planning programs that are used by the donors (including USAID/B and the World Bank Consortium).

3.3.1 Findings

Under the FPLM/Dhaka project, more than 11,000 family planning workers, supervisors, and storekeepers have been trained in the principles of logistics management. FPLM/Dhaka is also beginning an intern program whereby selected DFP logistics staff persons work alongside the FPLM/Dhaka staff.

FPLM/Dhaka has designed and implemented with the DFP an automated logistics information system, with 90 percent of the 467 *thanas* reporting logistics data on a monthly basis, and has undertaken improvements in the storage and warehousing of contraceptives.

FPLM/Dhaka maintains four logistics support officers who operate out of the DFP's central warehouse and three regional warehouses. The project recently successfully pilot tested a privatization scheme in the Dhaka supply region in which contraceptives are transported from the central warehouse to district regional stores and *thana* stores using private carriers.

Other FPLM/Dhaka activities include contraceptive procurement training to selected DFP staff persons in the procurement cell; needs assessment of the NGO logistics systems; maintenance of a continuous physical inventory system; and special logistics and stock surveys.

A 1994 survey of contraceptive stocks in the NGO program revealed that stock-outs were common, especially for injectables and intrauterine devices (IUDs) (over 30 percent and 25 percent, respectively). Such stock-outs run counter to the GOB first priority of increasing the use of clinical methods.

3.3.2 Conclusions

At one level a great deal has been accomplished by the project over the last several years in improving the distribution of contraceptives in the GOB program. Rates of contraceptive stock-outs at the field level (i.e., *thanas*) have declined dramatically from 23 percent in 1989 to under five percent by 1994. The sharp drop in field level stock-outs coupled with the large rise in the quantity and types of contraceptives distributed is indicative of significant improvements in contraceptive supply management. (See also UNFPA, *Contraceptive Requirements and Logistics Management Needs in Bangladesh*, 1994.)

The improvements in the program's supply management have contributed to the impressive increase in contraceptive prevalence in Bangladesh. But these accomplishments have not been achieved without cost, principally with respect to institutionalization and efficiency. The degree of institutionalization of logistics management within the DFP is disappointing. Maintenance of the logistics system is heavily dependent on external assistance from the large FPLM/Dhaka staff; this dependency is likely to continue for the next several years at least. At the central level the logistics information system is operated largely outside the government's

management information system (MIS) Unit.⁴ The forecasting of contraceptive requirements for the GOB program is still undertaken entirely by FPLM staff. There is also some question as to whether the logistics system which FPLM/Dhaka helped create is sustainable in its current form by the GOB alone. To promote greater sustainability, FPLM should assist the GOB in identifying options to increase the institutional sustainability of the contraceptive logistics system. As a first step in this process, FPLM should continue and expand the experiment of contracting with the private sector for distribution services, more fully integrating the logistics information system into the Ministry's MIS Unit, and strengthening local capability in contraceptive forecasting.

Another major issue facing the GOB's family planning logistics system is efficiency. While effective in minimizing stock-outs, the system needs to become generally more efficient, especially if it is to handle the anticipated increased volume of contraceptives in future years. The 1994 UNFPA Report, *Contraceptive Requirements and Logistics Management Needs in Bangladesh*, estimated a tripling in the number of users of modern contraceptives from 6.4 million in 1991 to over 20 million in 2006. Given the popularity of supply-based methods (especially oral contraceptives), this growth in demand for contraceptives will present significant challenges to the GOB's supply system. A related issue is the longer-term need for the GOB to assume full responsibility—including institutional and financial—for managing contraceptives (and other MCH supplies) provided by the MOHFW.

While the logistic system has improved substantially in the government's program, the NGO logistic system requires strengthening. Although the level of stock-outs was low for pills and condoms, a substantial proportion of fieldworkers had less than one month of supplies on hand.⁵

There are several FPLM/Dhaka activities that are low priority and can be shelved if there are time and resource constraints in the next two years: further training of DFP staff in the procurement cell and additional large-scale, formal logistics training. For the remainder of the FPHS Project, logistics training for DFP staff should be oriented toward on-the-job training including an expanded intern program with selected GOB (and NGO) staff. A possible exception is that some formal training may be needed for selected NGO staff persons in the area of forecasting contraceptive requirements.

3.3.3 Recommendations

Between now and the end of the FPHS Project, logistics assistance activities should concentrate on accomplishing the following:

8. To facilitate institutionalization, FPLM/Dhaka should transfer responsibility for managing the logistics MIS to the MIS Unit of the DFP.

⁴ It was not until 1994 that the logistics management information system (LMIS) was co-located within the DFP's MIS Unit. But even now the LMIS is maintained by FPLM/Dhaka staff rather than DFP staff.

⁵ The percent of NGO fieldworkers facing a potential stock-out situation (i.e., less than one month of supply on hand) was 70 percent for pills, 59 percent for condoms, and 38 percent for Depo-Provera.

9. FPLM/Dhaka should provide basic logistics assistance and training to selected national-level family planning NGOs to improve the stock situation in this sector.
10. DFP should continue, and perhaps expand, the recent experiment to privatize the transport of contraceptives from central to *thana* warehouses in the Dhaka district.
11. FPLM/Dhaka and the GOB should identify and train appropriate DFP staff persons in techniques of contraceptive forecasting.
12. GOB and FPLM/Dhaka should develop alternative strategies and options for DFP for making the contraceptive logistics system sustainable (both institutionally and financially).
13. USAID/B should initiate dialogues with appropriate parties on three key policy issues concerning future directions in managing contraceptive supplies: (a) the pros and cons of separate logistics distribution systems for the NGOs; (b) the pros and cons of privatizing portions of the DFP's contraceptive logistics system (e.g., transport, storage, and warehousing); and (c) alternative strategies and options to enable the National Family Planning Program to handle triple the current volume of contraceptives by 2005 efficiently and effectively.

3.4 Municipal Immunization

This section represents the urban portion of a National Program to reduce mortality and morbidity of infants, children, and women of childbearing age through immunization with polio, DPT, TT, BCG, and measles vaccines. The specific objective is to assist municipal governments to achieve and sustain 85 percent coverage for all children by their first birthday and 100 percent immunization with TT for women of childbearing age (15-45 years). The program elements involve the following:

- Ensuring the availability of immunization services at fixed and outreach sites.
- Developing an efficient routine epidemiological surveillance system to assess progress of the program.
- Improving the management of EPI service delivery systems in the urban areas.
- Addressing sustainability through political support, involvement of relevant government sectors and other organizations, and local resource mobilization.

3.4.1 Findings

USAID/B has provided technical assistance for planning, management, and evaluation since 1988 through three different intermediaries; since 1994 there is only one expatriate advisor serving as country representative and one urban EPI advisor under the Partnership for Child Health, Inc. (the Basic Support for Institutionalizing Child Survival [BASICS] Project CA). The project assists the National EPI Program with a communications advisor, a monitoring and evaluation specialist, and a government liaison advisor. Work is decentralized to nine urban

operations officers located in UNICEF's four divisional offices under a UNICEF-BASICS cost-sharing partnership.

The urban EPI program covers the four major cities (Dhaka, Rajshahi, Khulna, and Chittagong) and 84 out of 113 municipalities with a combined population of 22 million (20 percent of the national population).

Because there is limited GOB health infrastructure in urban areas, unlike the rural MOHFW system, the project, in conjunction with the urban EPI program, has had to pull together multiple disparate resources to set up fixed and outreach EPI centers. These have included GOB hospitals, municipal and private clinics, plus NGO hospitals, clinics, and dispensaries.

Critical to the success of the program has been the close collaboration between the MOHFW's National EPI Program, the USAID/B-supported urban FP/MCH OR project, the Ministry of Local Government, Rural Development, and Cooperatives (MLGRDC), municipal governments, UNICEF, and many NGOs.

USAID/B has supported institutionalizing urban EPI by coordinating with the World Bank in setting conditionalities in aid agreements that the GOB must assign primary responsibility for urban health and family planning to either the MOHFW or the MLGRDC.

These conditionalities have led to establishment of an Interministerial Urban Primary Health Care (PHC) Task Force that has established a framework for city and municipal leadership in implementing urban health and family planning programs.

Specific accomplishments from this project include the following:

- The level of immunization for both urban infants and urban mothers increased from under 25 percent in 1988 to over 80 percent by 1992. Given the limited GOB investment in urban areas, the urban project played a substantial role in urban achievements. Table 1 shows data obtained by the 1994 National Coverage Evaluation Survey.

TABLE 1

| URBAN AND NATIONAL IMMUNIZATION RATES (1994) | | |
|---|-------|----------|
| | Urban | National |
| Mothers covered with 2+ doses TT | 82% | 80% |
| Children ages 13-24 months with: | | |
| BCG | 93% | 96% |
| DPT3 | 83% | 88% |
| Measles | 76% | 86% |
| Fully immunized | 75%* | 84% |

* Based on a larger sample, the percent of urban children 13-24 months fully immunized was estimated at 83 percent +/- 5.5 percent. More effort is needed, however, because the percent of urban children under 11 months fully immunized is only 58 percent (62 percent nationally) and coverage in slum areas is even lower. In spite of this, it is clear that the supported project has made a significant impact, especially in the urban areas.

Source: 1994 National Coverage Evaluation Survey

- The EPI activities in the urban areas are operationally well integrated with FP service delivery through the major involvement of the NGOs, many of which are supported by USAID-funded CAs. This has also resulted in better FP performance, based on a study in Khulna city which showed that mothers who received either contraceptive methods or counseling during an EPI session had a higher modern CPR, 58 percent versus 33 percent.
- The urban operations officers are beginning to involve the city and municipal administrations in coordinating and managing the EPI program. This involves integrating the health and FP efforts of multiple institutions at the local level and is leading to initial fiscal allocations by cities and municipalities toward setting up municipal health systems.
- The Interministerial Urban PHC Task Force's recommendations were adopted by the secretaries of the MOHFW and MLGRDC. These recommendations, incorporated into the National EPI Program concept paper (later ratified at the highest level in the final MOHFW project proforma) have formally established the following:
 - * The MOHFW and the MLGRDC will have joint responsibility for urban health programs. This will be institutionalized through an Interministerial Urban PHC Coordinating Committee chaired by the secretary of the Local Government Division (LGD).
 - * Cities and municipalities will be the implementing agencies for the urban health programs. This will be achieved by creation of city PHC coordinating committees to plan, coordinate, implement, supervise, and monitor programs at the local level under the leadership of city mayors with technical assistance from district health and family planning managers.

- * These two actions are critically important in laying the foundation for effective municipal health authorities, and, in fact, are a first step in the process of decentralization of selected government services.
- * The project supported various research studies, among which the urban communications study found that poor urban mothers rely most heavily on direct communication from health workers for their knowledge about EPI. This finding led to the collaborative development of the Interpersonal Communications (IPC) Module for EPI. Currently, over 50,000 fieldworkers (health assistants [HAs], FWAs, and municipal and NGO workers) have completed training in IPC nationwide.

3.4.2 Conclusions

The urban population in Bangladesh is growing at about seven percent per year. Already Dhaka is among the world's 15 largest developing cities and among the top five fastest growing cities in the world. The urban population is projected to double in the next decade, with one-third or more being poor slum dwellers. In this circumstance, there is an urgent need for effective urban health systems.

Through its intermediaries, USAID/B has been instrumental in bringing together the MOHFW and the MLGRDC to form the Interministerial Urban PHC Coordinating Committee chaired by the Secretary of LGD. This is having far-reaching and potentially very positive consequences for both urban health systems in Bangladesh and effective integration of health and family planning activities at the local level.

The BASICS Project has proven effective, not only in strengthening implementation but also in developing useful and practical tools for monitoring program performance.

3.4.3 Recommendations

14. Priorities that USAID's urban immunization project should address in the next two years include the following:
 - Strengthen the disease surveillance system and further develop program monitoring tools (such as the lot quality assessment methodology) in order to improve the quality and coverage in the urban areas.
 - Strengthen the capacities of MLGRDC, city corporations, and municipalities to plan, coordinate, implement, and manage the EPI and related essential MCH services in order to help develop functioning urban health systems.

- Actively follow up and support the activities of the Interministerial Urban PHC Coordinating Committee to assure that needed new directives on implementing urban health care systems are formulated and disseminated to strengthen and bring the necessary support for the development of city and municipal health authorities.
 - USAID/B should assist BASICS to make the transition vis-à-vis the GOB from providing TA in only urban EPI management to an expanded role of assistance to other high impact child survival (CS), reproductive health (RH), and FP programs. EPI should serve as the entry point for reaching mothers with other essential services.
15. USAID/B should continue to support an urban PHC initiative, building on the gains already achieved with the EPI program, by further developing leadership in the MLGRDC and in cities and municipalities (long-term recommendation).
 16. The strategic approach of mobilizing, coordinating, and tapping into existing resources to build an integrated PHC system, initially around EPI, FP, and related MCH services, should be continually developed in the urban areas (long-term recommendation).

4 COMPONENT II: THE SOCIAL MARKETING COMPANY

4.1 Background

At the request of the government of Bangladesh, USAID/W began supporting social marketing of contraceptives in Bangladesh in 1974 through a sole source two-year contract to Population Services International (PSI). PSI then signed an agreement with the GOB establishing the Social Marketing Project (SMP) as a parastatal organization with a mixed sector project council. Products were introduced in late 1975. In 1982, after two contract renewals, USAID/B switched to the cooperative agreement mechanism to provide continuing support for the social marketing program. A year later, the project added ORS to its products. Since that time, PSI has had separate cooperative agreements with USAID/B running concurrently, one for family planning and one for ORS. In 1990, following protracted negotiations with the GOB and USAID/B, the Social Marketing Company became a non-profit private limited Bangladeshi company with a volunteer board of directors, all of whom represent the private sector. USAID/B contributed all social marketing condoms until 1993 and continues to provide one oral contraceptive (OC) (residual stocks of Maya and Ovacon, now discontinued, remain through 1996). Aside from a small initial stock of USAID-supplied ORS, SMC has purchased ORS on the local market. PSI has provided continuous resident support.

4.2 Findings

The social marketing initiative in Bangladesh has grown significantly in many dimensions in the last 10 years. See Table 2.

TABLE 2

| GROWTH OF SMC (1984-1994) | | |
|--------------------------------------|--------------------|--------------------|
| Dimension | 1984 | 1994 |
| Condom sales | 115,054,000 pieces | 150,993,000 pieces |
| OC sales | 2,179,000 cycles | 11,582,000 cycles |
| ORS sales | 35,000 sachets | 32,672,000 sachets |
| Revenue | 17,682,000 taka | 164,408,000 taka |
| CYP | 958,000 | 1,897,000 |
| Sales force size | 53 | 82 |
| Stockists | 3,500 | 8,000 |
| Retail outlets | 20,000 | 84,500 |
| Operating cost recovery | 21% | 92% |

SMC provides 60 percent of the condom market, 18 percent of the pill market, and 80 percent of the ORS market in Bangladesh.

Of the SMC-specific annual output indicators in the project paper supplement, SMC's achievements are listed in Table 3.

TABLE 3

| ACHIEVEMENT OF ANNUAL PROJECT PAPER INDICATORS | | |
|---|---------------|------------------|
| PP Output Indicator | 1997 Target | Achieved (12/94) |
| CYP | 1.5 million | 1.5 million |
| Condom sales | 139.5 million | 151 million |
| OC sales | 17.5 million | 12 million* |
| Injectables sales | 0.5 million | 0** |
| ORS sales | 17 million | 33 million |
| Cost recovery*** | 42% | 35% |

*SMC's sales have been adversely affected by changes in USAID/W's OC suppliers (causing brand changes) and USAID/W's decision to reduce its commodity support from three brands of pills to one.

**SMC has recently received permission from the GOB to market these products and is evaluating the feasibility and appropriateness of doing so.

***The project paper supplement does not specify the cost basis on which the target recovery percentage is based. The December 1994 figure in the table is based on total costs, including donated commodities. Considering only SMC's in-country operating costs, including the purchase of ORS, SMC's cost recovery rate was 67 percent.

Through December 1994, by virtue of good management and effective USAID/B support, SMC has achieved or exceeded all of the major non-financial outputs specified in the current USAID-PSI cooperative agreements, except in OC sales (see footnote to Table 3) and in the training area. The training shortfall results in part from long delays by the GOB in clearing SMC vehicles. See Table 4.

TABLE 4

| ACHIEVEMENT OF COOPERATIVE AGREEMENT OUTPUTS | | |
|---|----------------|------------------|
| Output | Target (12/94) | Achieved (12/94) |
| Condom sales | 187 million | 203 million |
| OC sales | 19 million | 16 million |
| ORS sales | 39 million | 43 million |
| CYP | 3.3 million | 3.3 million |
| % of fertile couples protected | 8.8% | 8.8% |
| Pharmacists trained | 14,850 | 7,751 |
| RMPs trained | 22,500 | 25,026 |
| School children trained | 145,000 | 102,026 |

SMC has sponsored evaluations of its training programs. These evaluations indicate that the training is not sufficiently effective in developing the target knowledge and skills among

trainees. SMC is in the process of revising curricula toward improving this aspect of operations.

Since becoming a private company in 1990, SMC, with support from PSI, has focused considerable attention on strengthening the company as an organization. For example, PSI arranged for Arthur D. Little, Inc. to engage SMC in a comprehensive strategic planning exercise. This has resulted in a comprehensive strategic plan that mobilizes the organization toward business objectives. It has also resulted in a system for continuous plan updates by rolling forward from year to year. As another example, SMC arranged for a local firm to conduct a detailed training needs assessment to direct the company's staff development program.

SMC has attracted new donors, with the European Union (EU) providing condoms and the Overseas Development Administration (ODA) providing one brand of low-dose OCs. In addition, at the time of this evaluation, UNFPA was planning to contribute a condom manufacturing plant and a pill tableting operation for SMC to operate.

The Community Based Sales (CBS) program, a pilot test of distributing SMC products through community-based women selling on margin, is now in Phase II, expanding from three to 19 *thanas*.

4.3 Conclusions

SMC is the world's largest social marketing company, a significant factor in service expansion in Bangladesh, and a highly successful component within USAID's population assistance package.

For a variety of reasons, the move toward financial and managerial sustainability has been slow, but the pace is rapidly accelerating. This is the result both of the conversion to private company status and the concerted efforts of USAID/B, PSI, and SMC.

SMC has demonstrated its expertise in marketing and distributing short-term contraceptive products as well as ORS, and its sales force has a reputation for excellence throughout the country.

It is too early to draw conclusions about the effectiveness and efficiency of the CBS operation for SMC itself. The intention was to develop a model for NGOs, but the level of interest among NGOs in adopting the approach has been limited to date.

SMC is becoming increasingly attractive to other donors. Multiple donors will place additional management demands upon SMC. The participation of other donors will also affect the level of influence USAID can maintain with respect to SMC.

Training is the weakest of SMC's activities. In response to training evaluations, efforts are underway to improve the program, and these efforts need continuing attention.

SMC's strategic plan has successfully focused attention on structured approaches to strengthening the company and increasing cost recovery. It has also established within the company a clear vision for the future, channeling efforts toward specific business objectives.

Product changes resulting from changing donor support patterns have disrupted the sales operation, requiring new promotions to advertise new products and limiting SMC's capacity to segment its market. These changes have been beyond SMC's control, but they have undoubtedly affected cost recovery. Continued competition with the GOB's free provision of OCs has also affected cost recovery.

USAID/B plans to phase out its agreement with PSI for support of SMC in late 1996 and, instead, contract directly with SMC. As a result, SMC is now entering a transition phase, particularly in terms of managerial sustainability. A successful transition would be ill served by abrupt changes in technical support. A far better approach would be a gradual, orderly transfer of responsibilities and authorities, allowing SMC to articulate and arrange to fill its own technical assistance needs. If SMC meets the financial management criteria to become a direct recipient of USAID/B funds, it is essential that the USAID/B-SMC agreement (1) permit SMC to subcontract for technical assistance services using USAID/B funds and (2) afford SMC flexibility in determining the configuration of these services.

SMC's strategic plan designates a number of new activities to be undertaken during the transition phase and beyond. In addition, SMC is planning to enter the manufacturing arena. Caution is needed on the part of SMC and the donors in determining the number and complexity of new tasks to be undertaken concurrently.

4.4 Recommendations

17. USAID/B, SMC, and PSI should begin now to establish a transition strategy for the remainder of the present project period and the early phase of the follow-on project.
18. The determination regarding SMC's eligibility as a direct recipient should be made as soon as possible.
19. To sustain SMC as a major player in the GOB family planning program and to promote the company's growth, USAID/B should prepare to provide continuing commodity and operational support, monitoring and basing support levels on actual cost recovery patterns.
20. SMC should focus its efforts on its main promotion and sales activities. The decision to continue or discontinue CBS should be based on the value of this operation to SMC alone (e.g., on a commercial basis), as should other expansion decisions.
21. SMC should strengthen its training programs as well as its training monitoring activities to enhance their efficiency and effectiveness.
22. SMC should carefully evaluate the management and other demands associated with its proposed new ventures, ensuring that it has sufficient and appropriate staffing and that the phase-in of these activities is realistic and manageable.

5 COMPONENT III: NGOs

5.1 Background

The FPHS NGO component has created a unique private sector delivery system through its extensive network of 115 NGOs that provide approximately 19 percent of the country's overall FP services. This component will have been allocated approximately one-third of the total project funding (US\$97 million out of a total US\$300 million). It is implemented through four cooperative agreements with AVSC, Pathfinder, The Asia Foundation (TAF), the Family Planning Association of Bangladesh (FPAB), and one separate agreement with the Family Planning Services Training Center (FPSTC). Pathfinder, TAF, FPAB, and FPSTC focus mainly on providing grants and technical assistance to 115 local NGOs operating at 332 delivery sites in all six divisions of Bangladesh to provide FP/MCH services. AVSC focuses almost entirely on providing technical assistance in quality training to both the public sector and NGOs.

The project document expected the CAs to achieve the following by 1997:

- Increase users from 1.7 million (in 1994) to 3.2 million.
- Meet or surpass established QA criteria.
- Increase revenue generation of the NGOs by 15 percent.

The NGOs are partners in the National Program and function as innovators and catalysts of new program interventions. In 1992, USAID/B developed the Quality, Expansion, and Sustainability (QES) strategy to focus local NGO activities on the following:

- Improving services through development of quality assurance and infection prevention practices.
- Expanding services to low performing areas and underserved groups.
- Enhancing institutional, managerial, and financial sustainability of the NGOs.

In addition, each CA was assigned prime responsibility for a functional specialty:

- AVSC—quality assurance
- FPAB—IEC and logistics
- FPSTC—government coordination and management training
- Pathfinder—operations research
- TAF—training

5.2 NGO Service Delivery: Findings

5.2.1 General

It is estimated that in 1994 the CAs/NGOs served 1.7 million users (approximately 17 percent of the estimated 10.1 million users). Whether this can be increased to 3.2 million by 1997 depends in part on rapid implementation of some of the recommendations of this evaluation.

As shown in Table 5, all the CAs have modern method CPRs that are significantly higher than the national level of 36 percent. Although clinical methods are a higher proportion of all modern methods nationwide than they are in NGO programs, between 1993 and 1994 clinical methods in NGO programs increased slightly as a percentage of modern methods. Moreover, at the national level, clinical methods, as a percent of modern methods, declined slightly from 47 percent in 1991 to 46 percent in 1993-94.

TABLE 5

| NGO CPR AND CLINICAL METHODS STATISTICS (1992-1994) | | | | |
|--|-----------------------------------|------|---|------|
| | CPR (modern methods) (percent) | | Clinical Methods (percent of modern) | |
| | 1992 | 1994 | 1992 | 1994 |
| National * | -- | 36 | 47 | 46 |
| Pathfinder | 53 | 54 | 32 | 36 |
| TAF | 59 | 61 | 36 | 38 |
| FPAB | 60 | 57 | N/A | 20 |
| FPSTC | 59 | 59 | 33 | 35 |

*The national modern CPR of 36 percent is for 1993/94; the nationwide rate of 47 percent of modern CPR for clinical methods is for 1991 and 46 percent is for 1993/94.

In regard to sustainability, all USAID-supported NGO fieldworkers charge for contraceptive services. A portion of these funds are used to purchase reproductive tract infection treatment medicines, although most of the revenue is placed in interest-bearing accounts by the NGOs. Since USAID/B established no baseline to quantify as a revenue base, as required by the logframe, the evaluation team was unable to assess if the NGOs increased revenues by 15 percent as set forth in the project document. At present, NGOs are covering about four percent (range between one percent and 20 per cent) of their costs through cost recovery and revenue generation.

The CA functional specialties received a mixed review. FPAB management of logistics would benefit from additional assistance from FPLM/Dhaka. The operations research completed by Pathfinder has been slow, but of excellent quality. There is fairly good coordination of training needs through TAF. AVSC has taken the clear lead in initiating quality assurance with excellent collaborative support from Pathfinder. The CAs/NGOs have been extremely influential in serving on all nine working groups and on the National Steering Committee for the FP-Future Challenges Framework. For example, through their high levels of contact on the National Steering Committee, the NGOs have influenced the GOB to initiate outreach to newlyweds and low-parity couples in government programs.

The CAs have not had difficulty in overseeing NGO grants, but several have rather limited ability to provide high-level technical assistance in strategic planning to their NGOs. For example, the CAs have been unable to achieve an output contained in their cooperative agreements stating that all their NGO sub-grantees would develop long-term sustainability

plans. This output was to be achieved by 1994 but was not accomplished by any CA; this could be related to limited staff skills in strategic planning.

5.2.2 Quality

All CAs and many NGOs have greatly increased the number of fully qualified doctors on their staffs to monitor quality.

Although traditional supply method community-based distribution (CBD) is still the main focus of the CAs/NGOs, a number have increased acceptor choice by providing their own well-trained FWVs who can insert IUDs and give injections. It is noteworthy that, after these staff changes, Pathfinder's clinical methods CPR increased by four percentage points in a single year.

The NGOs' clinics, in general, appear to have adequate equipment and trained providers. Counseling has improved with refresher training, but recent surveys have shown that much method switching can still be attributed to poor counseling.

Some of the CAs/NGOs have indicators to monitor quality of services, but local-level implementation is problematic as some of the NGOs lack physician back-up. In addition, NGO clinics are inspected by official surveillance teams only once every three years on average.

Studies show that time spent with clients is short, and there is a large discrepancy in the type of information women receive when confronted with method problems. This is an extremely important finding that exists in urban as well as rural clinics and doubtless is a major factor in high discontinuation rates and method switching.

The capabilities of workers who come in direct contact with clients need to be upgraded particularly in regard to their understanding of new information, their knowledge of side effects and myths, and in their counseling skills. Discontinuation rates should decline and client satisfaction and changes to more appropriate contraceptive methods, e.g., clinical methods, should increase with refresher training.

5.2.3 Expansion of Services

The CAs/NGOs have been the key catalysts in expanding coverage in four ways: (1) access to services for underserved groups, (2) expansion at existing service sites, (3) geographic expansion to new areas, and (4) expansion of use of innovative delivery systems. The CAs/NGOs have been especially instrumental in increasing access of services to underserved groups, primarily newlyweds and low-parity couples (see Table 6 for 1994 rates) and, more importantly, in influencing the government to target these heretofore neglected groups as well.

TABLE 6

| NGO CPR FOR NEWLYWEDS AND LOW PARITY COUPLES (1994) | | |
|--|----------------------------|-------------------------------------|
| | Newlyweds CPR (percent) | Low Parity Couples CPR (percent) |
| National | 9 | 29 |
| Pathfinder | 35 | 54 |
| TAF | 24 | 54 |
| FPAB | N/A | N/A |
| FPSTC | 28 | 55 |

5.2.4 Sustainability

This is the area in which the CAs/NGOs have made the least amount of progress. Financial sustainability can be reached through greater internal cost efficiency, fees-for-service, integrated services, cost recovery/enhancement from non-FP medical activities, and voluntary contributions. Although all USAID/B-supported NGO fieldworkers now charge for contraceptives, only two national NGOs have made a systematic effort to increase external donations. No effort has been made to contain salary costs. For example, with USAID/B permission, CAs recently increased salary levels significantly.

The majority of clients are willing to pay a small amount for services. The NGO sustainability evaluation (March 1995) indicates that two-fifths of clients lack the means to pay.

While progress has been made by most NGOs in institutionalizing sustainability, this effort is still in its early stages. For example, the current supervisory ratios and non-targeted visitation patterns are not cost effective. There is resistance by CAs and NGOs to maximizing the use of village depots or increasing satellite clinics.

Where NGOs make the effort to be advocates, they are highly successful at involving their communities in supporting FP/MCH efforts.

5.3 Conclusions

USAID/B has made a sound investment in supporting the NGOs. They have been key innovators in pushing the program forward and influencing national policy. More importantly, they have served as catalysts to improve the quality of care at government sites and have convinced the government of the efficacy of targeting newlyweds and low-parity couples.

The NGOs have met or exceeded their CPR requirements.

The NGOs have adopted the QES strategy throughout their delivery systems, but the synergistic effect of the three elements on overall impact is not well understood even at the CA level.

Counseling and refresher training need to be strengthened.

The NGOs have done very little to widen their resource base or implement cost-efficiency/cost-reduction strategies.

The NGOs have been successful in increasing access to underserved groups; however, expansion of service sites has created duplication of services in some areas. Many of the clinics are underutilized and do not warrant separate facilities and personnel.

The two-year period should serve as a bridge for the National FP/MCH Program to consider programmatic modifications to the CBD program in order to enable it to reach its demographic and health goals.

5.4 Recommendations

23. USAID/B should work with the national NGOs and CAs to develop a joint five-year strategic plan that would focus on CAs' designing delivery service systems able to provide quality services and information in a cost-effective, client-sensitive manner.
24. NGOs should accelerate the phase-down of doorstep delivery, beginning with high performance areas, through the use of depots, satellite clinics, and selective visitation patterns targeting underserved high-risk groups.
25. NGO efforts need to be intensified in the next two years and beyond to ensure that quality of services is further improved, services are expanded both vertically and horizontally, and sustainability is further addressed.
26. USAID/B should see that a fully functioning supervision system is in place to ensure quality service delivery. This supervision system should include a cadre of quality surveillance teams to monitor and correct deficiencies as soon as possible.
27. Quality of service delivery should be improved at both the static and satellite clinics. An independent study should be conducted to assess the quality of both types of clinics and the efficacy of increasing the number of NGO satellite clinics and reducing the number of low-performing static clinics.
28. CAs should accelerate the distribution of infection prevention, quality assurance, and clinic waste disposal manuals, IUD kits, and portable sterilizers if permitted under current agreements.
29. NGOs should assist in a structured manner in the improvement of service delivery and skills training of government personnel if necessary and if requested to do so by the GOB.
30. NGOs should focus efforts on their areas of comparative expertise. Not all NGOs should provide both clinical services and CBD. NGOs with only CBD programs must have referral sites with quality clinical services. Traditional IEC should also be limited; rather NGOs should focus on community advocacy efforts.

31. By the end of the project, USAID/B should develop and implement an assessment tool to determine which NGOs have expertise in providing clinical services and should revise traditional CBD models, if appropriate.
32. By December 1996, in line with the written agreement between the NGOs and USAID/B, each NGO should have a long-term sustainability plan. Implementation of their sustainability plans should be a criterion for participation in the next project.
33. USAID/B should develop additional objective criteria to establish the parameters (e.g., number of ELCOs covered) that an NGO must possess prior to receiving funding in the next project.
34. AVSC should continue to focus on improving quality in the National Family Planning Program, including expediting training for private physicians.
35. AVSC should postpone further training of foreign physicians in clinical skills until there are adequate caseloads for quality training of Bangladeshi doctors. This recommendation is not intended to prevent South-to-South exchange; rather, AVSC should continue to send qualified Bangladeshi physicians abroad to train host-country doctors, as appropriate.

6 COMPONENT IV: PROGRAM SUPPORT SERVICES

6.1 Contraceptives

6.1.1 Findings

All contraceptives distributed in Bangladesh through the public sector, the NGOs, and SMC are provided by donors, principally UNFPA, USAID/B, and the World Bank Consortium. Contraceptives are distributed through three channels: the DFP, SMC, and NGOs. The contraceptives provided by the DFP and the NGOs flow through the DFP logistics system. SMC has its own contraceptive distribution system.

Since 1987, USAID/B has provided US\$71.1 million worth of contraceptives to the Bangladesh family planning program (see Table 7). The vast majority of the contraceptives were provided prior to 1992. Since 1992, the EU has resumed responsibility for supplying condoms to the National Program, including to the SMC. USAID/B continues to provide oral contraceptives to the SMC.

TABLE 7

| CONTRACEPTIVES PROVIDED UNDER THE FPHS PROJECT (1987-1995) | | | |
|---|----------------|---------------|----------------|
| | Condoms | IUDs | Orals |
| Public Sector (including NGOs) | 321,804,000 | 2,373,000 | -- |
| Social Marketing | 695,832,000 | -- | 73,483,000 |
| Total | 1,017,636,000 | 2,373,000 | 73,483,000 |
| Total Value | US\$48,343,688 | US\$2,556,366 | US\$20,174,152 |

In addition to providing contraceptives, USAID/B is supporting the construction of 210 *thana* storerooms for the DFP. To date, only 18 have been completed and are operational and another 92 are presently under construction. The remaining 100 *thana* storerooms are expected to be complete by the end of the FPHS Project. This activity has been plagued with numerous delays and implementation problems including difficulties with contractor performance as well as USAID/B and GOB bureaucratic obstacles.

6.1.2 Conclusions

In the future USAID/B should avoid becoming engaged in physical infrastructure development; it is not an area in which USAID excels. Since USAID/B has experienced delays in contracting, GOB bureaucratic delays, and non-performing contractors in storeroom construction, it may be that other donors, such as the Japanese and the World Bank, may be better equipped to manage and implement this aspect of development assistance in the future.

The donors will continue to supply the contraceptives needed for the National Program at least for the near term. Yet, whether or not in the longer term the GOB purchases contraceptives on the international market or through local facilities, the GOB needs to develop a realistic plan for securing its contraceptive requirements after 1997 when many of the current donor projects end.

6.1.3 *Recommendations*

37. USAID/B should encourage the GOB to chair a donors meeting in 1995 and develop a plan that identifies funding sources (and gaps) to meet the program's contraceptive requirements after 1996-97.
38. USAID/B should complete construction of the remaining *thana* storerooms for contraceptives. However, USAID/B should resist strongly future requests for assistance in physical infrastructure development and/or maintenance activities.

6.2 **Research, Evaluation, and Monitoring**

The purpose of research, evaluation, and monitoring (REM) is to improve national policies to contribute to (1) increasing the use of FP and MCH services, (2) improving the quality of care, and (3) developing sustainable service delivery structures through research and policy dialogue. REM activities are classified into three major categories with technical assistance to support them: (1) applied/operations research, (2) demographic surveys and analysis, and (3) sustainability studies and modules.

The project has supported these activities by involving national institutions and providing technical assistance from international organizations. These mechanisms are consistent with the important sub-objective of developing local institutional research and analytical capabilities.

6.2.1 *Findings*

Principal REM activities include the following:

- Applied OR including (1) the Rural FP/MCH Extension Project being implemented by ICDDR,B with technical assistance from The Population Council and the University of Michigan; (2) the Urban FP/MCH Extension Project also being carried out by ICDDR,B with technical assistance from Johns Hopkins University; and (3) other OR activities being carried out primarily under the auspices of Pathfinder International, under the oversight of a CAs/NGOs technical review committee by local firms with appropriate technical assistance from U.S.-based organizations.
- Demographic surveys, notably the 1989 contraceptive prevalence survey (CPS), the 1991 CPS (conducted by the National Institute of Population Research and Training [NIPORT] and a local Bangladeshi firm), and the 1993/94 Bangladesh DHS that was jointly carried out (together with a program of secondary data analysis) by NIPORT, Macro Inc., the East-West Population Institute (EWPI), and a local

Bangladeshi firm under the guidance of the national technical review committee. The 1996/97 Bangladesh DHS will be carried out under a similar agreement.

- Sustainability and cost studies, notably the FP cost-benefit analysis carried out by the Population Development and Evaluation Unit (PDEU), Planning Ministry, with technical assistance from the Resources for the Awareness of Population Impact on Development (RAPID IV) Project; the FP cost study carried out by PDEU with technical assistance from Family Health International (FHI); and the cost-effectiveness analysis that will be conducted next year by RAPID IV in collaboration with several GOB entities and private sector organizations.
- A range of both short- and long-term TA and training/capacity-building activities; e.g., (1) TA provided to PDEU for carrying out numerous policy analysis and policy/program advocacy activities; (2) TA provided to other government and nongovernment agencies such as MOHFW, NIPORT, the University Research Corporation/Bangladesh (URC/B), and the University of Dhaka; and (3) intensive technical training to technical staff of PDEU and other government entities and private sector organizations during the past two years provided at the East-West Center and in Dhaka.

Specific accomplishments and contributions of these activities include the following:

- The CPS/DHS surveys have documented the demographic impact of the National FP Program as well as a large potential for further increasing CPR and reducing fertility through delivering appropriate services to women (with "unmet need") who are not currently using any contraceptive method yet say they want either no more children or to delay the next birth at least two more years, as well as to those women who are using spacing methods but say they want no more births.
- The Rural and Urban FP/MCH Extension Projects are designed to test ways to bring service delivery innovations into regular government programs without major infusion of additional resources. Research staff interact closely with GOB policy-makers and program managers so that lessons learned from field experience can influence policy decisions and can be incorporated into mainstream GOB programs. In addition to working with MOHFW personnel, recently the urban project has begun collaborating with the MLGRDC, the Dhaka City Corporation, and NGOs such as Concerned Women for Family Planning. This new initiative provides an important opportunity for testing new organizational and service delivery structures in urban areas where existing government FP/MCH services are generally weak, spotty, and in many areas non-existent. The FP/MCH extension projects have developed a significant number of new, positive service delivery and programmatic policies to strengthen the National FP Program. Examples include the doorstep injectable program and the combining of satellite clinics and EPI outreach posts.
- NGO research and demonstration projects have also often provided results useful for program improvements. As one example, two years ago, 29 NGO family planning programs commenced a FP demonstration activity focusing on promoting use of contraception among newlyweds. Evaluations have shown that, contrary to

popular lore, a significant proportion of newlyweds (often a third or more) wish to use contraceptives to delay their first birth and will do so if quality information, services, and regular follow-up are readily available.

- The cost-benefit analysis of the National FP Program showed that expenditures on the National FP Program are an excellent financial investment for the government, with an estimated cost-benefit ratio of 1:5. This has influenced the government to mobilize additional resources for the program.
- Awareness-raising and advocacy activities, especially those undertaken in support of the December 1994 "Population Fortnight," energized high-level GOB leadership significantly, including the prime minister, as attested to by large numbers of GOB and donor participants and observers and as manifested in the subsequent formation of the "FP-Future Challenges Framework" which includes the National Steering Committee (NSC) and the nine working groups. Some of the Working Groups' recommendations are already being put into practice.

6.2.2 Conclusions

REM assistance has increasingly been directed to developing technical capabilities of nongovernment agencies to be used as "producers" of research and other priority technical analyses while also supporting provision of TA to GOB agencies and the private sector to develop their capabilities to be primarily "consumers"/users of research and analysis. This is a commendable development.

The need remains for increased technical capacity-building in key institutions, both within the GOB and in the private sector. For GOB agencies, the primary need is to increase their capabilities to understand what technical work is needed, how to interpret results of research and other technical work, and how to communicate the findings and implications most effectively to policy-makers and program managers.

Better use of results and findings from USAID/B-sponsored research and TA undertaken by the GOB and by the private sector would increase impact on policies and programs.

6.2.3 Recommendations

39. USAID/B should continue to develop technical capabilities, both in key GOB and private sector agencies, through supporting training and collaborative activities (between USAID/B, U.S. contractors, and Bangladeshi institutions) that transfer appropriate technologies and develop appropriate technical skills.
40. USAID/B should continue to give high priority to supporting OR related to management improvement, quality of care, and sustainability. USAID/B should also give priority to designing and testing alternative service delivery systems to address FP/MCH financial issues.

41. Through its support of research and capacity building, USAID/B should foster and support the development of a lively, growing, diversified, and competitive private sector research community.
42. USAID/B should continue to give high priority to supporting dissemination of research and analytical findings to policy-makers.

6.3 Information, Education, and Communication

The IEC component is a delivery support project designed to help achieve contraceptive prevalence goals by insuring that clients have an informed choice among methods and by promoting sustained use of family planning practices. Its broad objectives are to increase support for family planning among national leaders and policy-makers and increase community support for family planning at the village level.

The activity began in 1988 under a buy-in with the Johns Hopkins University Center for Communications Programs (JHU/CCP) to provide technical assistance to the Information, Education, and Motivation (IEM) Unit of the MOHFW, its contractors, NGOs, and other agencies.

Because of a lack of a comprehensive national IEM strategy coupled with slow implementation of activities programmed for the IEM Unit, the project was reformulated in 1992 to increase the support role of JHU/CCP, with emphasis to be given to extending a promising rural communication program (Jiggasha), expanding training and production of IEC materials, sponsoring national workshops for policy-makers, and communications and media research.

6.3.1 Findings

The production of the National FP/MCH IEC Strategy for 1993-2000 is a significant achievement involving 41 key players from government, NGOs, the private sector, and donors working under the guidance of the National FP/MCH IEC Strategy Committee headed by the additional secretary, MOHFW. Substantively, however, the document primarily addresses the FP issues and has little MCH content.

JHU/CCP has been selected as the lead agency in implementation of the strategy and produced an "Implementation Plan Outline" in March 1994 that has been accepted by the GOB, donors, and other agencies. Among key elements in the implementation plan are the following:

- A focus predominantly on family planning
- An emphasis on "informed choice" by providing full and accurate information on modern methods

- Promotion of actual FP services and providers rather than just awareness of concepts. This includes a logo campaign. (Controls for avoiding misuse of a logo are not fully developed.)
- Targeting of specific audiences, e.g., young married couples, couples with completed families, and men and directed to specific geographic markets, e.g., urban areas, Chittagong, etc.
- Design for maximum participation by GOB and NGO organizations seeking to improve their IEC capabilities and programs

The rural communication program (Jiggasha) re-directs the work of the FWAs, taking advantage of existing social networks to extend their reach by promoting family planning through Jiggasha or group discussion meetings. Instead of making house-by-house rounds (mostly to previous users based on IEC research), each FWA convenes three groups daily in Jiggasha centers with work extended by (unpaid) volunteer link persons. Since 1993, the activity was extended to eight *thanas* with 3,051 Jiggasha centers serving 294,061 eligible couples.

The Generic Curriculum for Interpersonal Communication and Counseling Training, the Fieldworkers Guide, and the Method Specific Booklet represent important examples of inter-organizational collaboration in production of training and IEC materials: 50,000 copies of the Fieldworkers Guide and 100,000 copies of the updated Contraceptive Method Booklet have been produced for distribution to the GOB and NGOs.

Workshops have provided 72 Bangladeshis with "advanced" training in communications, while other groups have been in workshops concerned with message development and media relations.

JHU/CCP has produced radio and TV spots, folk songs, a short feature film, and a 25-episode radio drama in support of FP/MCH. The radio drama is aired weekly free, as well as being used at the Jiggasha centers to initiate discussions on a range of topics related to FP/MCH and broader women's issues.

Operations research supports program interventions such as Jiggasha; JHU/CCP is collaborating with UNICEF and PSI/SMC in undertaking a National Media Survey which will guide future media campaigns by all agencies.

6.3.2 *Conclusions*

A key issue in IEC is coordination among all agencies and organizations concerned with FP/MCH communication. This is essential for many reasons, including avoiding costly duplication of effort; avoiding sending contradictory messages to clients, providers, and policy-makers; and assuring that limited resources are invested in the best expertise available for IEC activities.

Some operational coordination is now being achieved through two complementary mechanisms: first is the National IEC Strategy, which now is in the process of being

implemented; second, through national committees. In this context, JHU/CCP identified 12 national committees where coordination takes place, including, among others:

- National Steering Committee for Implementation of the National FP/MCH IEC Strategy (also the Executive Committee)
- MOHFW IEC Technical Committee
- NGO IEC Strategy Committee
- National Steering Committee for Strengthening FP/MCH Activities
- National AIDS Awareness Campaign Committee
- EPI Communication Advisory Committee

Due to lack of participation from the health side of the MOHFW in the strategy development, however, these coordination efforts have actually not been successful in developing a comprehensive IEC strategy that analyzes and addresses the needs in the MCH as well as the FP area. This is replicated in the lack of substantive MCH content in the FP/MCH strategy and implementation plan.

Another conclusion relates to capacities to be developed in the IEM Unit of the MOHFW. Currently these capacities are limited to development and production of basic in-house IEC materials in print and audiovisuals. Given the high level of sophistication now required to design, develop, and implement IEC programs, the international trend is for governments to contract out for most IEC services. In this context, the leadership in the IEM Unit sees the primary need as capacity building to develop staff persons who can conceptualize IEC strategies, develop requests for proposals (RFPs), and provide management and oversight to contractors in program implementation.

6.3.3 Recommendations

43. The implementation plan of the National FP/MCH IEC Strategy should be reformulated to support a more comprehensive and integrated FP/MCH effort, especially where there are now obvious opportunities and programmatic links (e.g., EPI and postpartum family planning, breastfeeding and child spacing, permanent methods and maternal health, etc.).
44. The proposed family planning provider promotion strategy with logos must be carefully coordinated with a clinical quality assurance program to avoid the perception of "endorsing" substandard providers and undermining efforts at promoting a message built around (certified) quality FP providers.
45. USAID/B should devote major attention to the evaluation of the cost-effectiveness of the Jiggasha program in the next two years to determine if it improves effectiveness/efficiency of work by the FWAs.
46. Investments should begin now in specific training to build capacities in the IEM Unit to develop and manage IEC programs implemented by private contractors (long-term recommendation).

47. JHU/CCP should begin to develop a private enterprise to sustain the local competencies now being built up in the project offices (long-term recommendation).